MINUTES
MEETING OF INPATIENT PHYSICAL REHABILITATION SERVICES
TECHNICAL ADVISORY COMMITTEE
Of the Health Strategies Council
2 Peachtree Street, 34th Floor Conference Room, Atlanta, GA 30303

Thursday, March 16, 2006
1:00 pm - 3:00 pm

Robert Rozier, JD, Presiding

MEMBERS PRESENT

Libba Bowling
Lillian Darden
Hazel Dorsey
Mitch Fillhaber (for Gary Ulicny, Ph.D)
Patricia Fraley
Ron Hunt, MD (via conference call)
John Lindsey
Dennis Skelley, FACHE
Diane Waldner
Wylene Watts

MEMBERS ABSENT

Pamela Cartwright
Edwinlyn Heyward
Kathy Kleinsteuber
Mary Sloan, MPA
Dayna Whitley
Brian Williams
Gene Winters
Carol Zafiratos

GUESTS PRESENT

Jennifer Bach, Mitretek Healthcare
Armando Bassarratte, Parker Hudson
Melissa Katz, Sullivan Consulting
Lou Little, WellStar Health System
Liz Schoen, GHA
Leah Watkins, Powell Goldstein

STAFF PRESENT

Rory Gagin
Richard Greene, JD
Bruce Henderson
Matthew Jarrard, MPA
Brigitte Maddox
Robert Rozier, JD
Virginia Seery
Rhathelia Stroud, JD
Carlos Williams

WELCOME AND APPROVAL OF MINUTES

The meeting commenced at 1:06 pm. Robert Rozier welcomed members and guests and asked for a motion to approve the following minutes:

- *Inpatient Physical Rehabilitation Services TAC, November 3, 2005*. A motion to accept these minutes was made by Dennis Skelley, seconded by Patricia Fraley.
- *Long Term Care Hospital TAC, February 7, 2005*. Two members of the subcommittee were present. Both members approved the minutes, as presented.

TAC members recognized Department staff for the thoroughness of the meeting minutes.

OVERVIEW OF THE PLANNING PROCESS FOR REHABILITATION, TRAUMATIC BRAIN INJURY (TBI) & LONG TERM CARE HOSPITALS (LTACH)

Robert Rozier reminded TAC members that the Long Term Care subcommittee was formed specifically to develop proposed Rules to regulate long term care hospitals. He said that the LTACH subcommittee met twice and has developed proposed Rules. He said that the proposed Rules were sent to LTACH subcommittee members. To date, the Department has received no feedback from subcommittee members with recommendations for changes, so it is assumed that the Rules are reflective of the subcommittee's work.

Mr. Rozier said that the draft Proposed LTCH Rules would be presented to the rehab TAC at today's meeting. He instructed members that they would need to decide, as a group, whether to accept the proposed LTACH Rules. He said that the Rehab Rules had been discussed and agreement had been reached, on most of the standards contained in the Rehab Rules. The only outstanding area where agreement needs to be reached for the Proposed Rehab Rules, is the numerical need methodology. He said that the TBI Rules would also be discussed today. He told members that there is significant overlap between the rehab and LTACH Rules.

REVIEW OF DRAFT PROPOSED LTACH RULES

Robert Rozier said that the following draft proposed Rules are included in member packets:

- 111-2-2-.36 - Long Term Care Hospitals; *(final draft 3/16/2006)*
- 111-2-2-.35 - Comprehensive Inpatient Physical Rehabilitation Services *(final draft 3/16/2006)* and
- 111-2-2-.34 - Traumatic Brain Injury *(final draft 3/16/2006)*

Applicability

Robert Rozier reviewed the applicability standard of the draft proposed LTACH Rules. He noted that this standard is the same that is required for Short Stay General Hospitals and Rehabilitation Hospitals.

Definitions

Robert Rozier reviewed all of the definitions contained under this standard. He noted the following:

- The acronyms, LTCH and LTACH, would be used interchangeably in the Rules.
- Medicare definition of an LTACH would be used in the Rules, namely facilities that provide services to Medicare patients that have an average length of stay (ALOS) of 25 days or more.

Mr. Skelley questioned whether the definition regarding average length of stay (ALOS) is limited to just Medicare patients or whether it includes all patients. Mr. Rozier explained that the current DCH Rule covers all patients, but subcommittee members proposed that the Rules reflect only Medicare patients.

He summarized that the proposed Rule would establish a time frame within which an applicant must become classified by Medicare as an LTACH. Failure to meet this Medicare classification within that established timeframe could result in the revocation of CON.

Wylene Watts asked about the consequences to a facility if it voluntarily or involuntarily gave up its LTACH designation.

Department staff explained that there are no set consequences, except if the established time frame to secure Medicare classification has not been met, the CON could be revoked. Department staff said that it is allowable for an LTACH to stop offering services up to 12 months. If the service were reopened within the 12 month period, there would be no need to submit a CON. An applicant would be required to submit a CON if they did not offer the service within the 12-month time frame. Department staff clarified that this is a statutory requirement.

Department staff discussed the time frames that are included in the LTCH definitions:

(a) Long Term Care Hospital' or 'LTCH' or 'Long Term Acute Care Hospital' or 'LTACH' means a hospital that is certified as a long term hospital by the Medicare program as per 42 CFR 413.23(e). For regulatory purposes, the definition includes a hospital which asserts its intent to be Medicare-classified as a long term hospital at the earlier of

1. *Twenty-four (24) months after the receipt of the Certificate of Need, if the construction required is in excess of $5 million; or*
2. *Eighteen (18) months after the receipt of the Certificate of Need, if the construction required is less than $5 million; or*
3. *Twelve (12) months after accepting its first patient.*

John Lindsey expressed concern about the criterion that requires an LTACH to be Medicare-classified as an LTACH within 12 months of accepting its first patient (a)(3). He said that Medicare Rules make it impossible to be classified by Medicare within 12 months of accepting the first patient because the Medicare Rule says that you have to operate as a rehab unit for one cost report period before a provider would be eligible to apply for classification as a rehab unit. Following additional committee discussion, it was agreed that (a) (3) above would be deleted from this standard.

Department staff said that as an alternative and in lieu of a capital threshold amount that the Department would start counting eighteen months from the time of admission of the first patient.

Department staff noted that these standards are aimed at preventing an applicant that received a CON to become a long term care hospital from operating as an acute care hospital. Following significant committee discussion, members agreed that the standard (a) (1&2) should read as follows: the facility must be Medicare classified as a long term care hospital within 24 months after accepting its first patient.

Department staff indicated that in order for a facility to have a valid CON, construction has to begin within 1 year of issuance of the CON; otherwise the CON would be revoked. This requirement is stated in the General Consideration Rules and not in the service-specific Rules. The current Rules require that a facility be classified by Medicare within a 24- month period after the receipt of the CON. The CON would be revoked resulting in the loss of authority to operate as a general acute care hospital.

Department staff noted that there will be one State Health Plan which would include the standards and rationale for Inpatient Physical Rehabilitation Services, Long Term Care Hospitals and Traumatic Brain Injury facilities. Department staff solicited member input regarding the correct name for the state health plan. Some members disagreed with the suggestion that it should be called a rehabilitation services plan. Members said that such a name would conflict with distinctions that Medicare makes for all of these long term care services. Department staff suggested that it may be more appropriate to give the State Health Plan a more global name such as "long term care services" since all of these services are subparts of this care continuum.

Discussion of types of beds

TAC members engaged in discussion about the different types of beds, namely CON authorized, Set-Up-Staff (SUS), and licensed beds. Department staff noted that CON authorized are those beds that were approved through the CON process; Set-Up-Staff beds are those that are operational by the facility and staffed for patient admission; while licensed beds (regulated by DHR/Office of Regulatory Services) are the maximum number of beds that the facility can legally operate, given physical infrastructure. Department staff noted that facility occupancy rates are calculated based on CON authorized beds; however, the beds referenced in the service-specific Rules are licensed beds.

Department staff explained that the current Rules would not permit the Department to take away any unused beds. Department staff noted that under these proposed Rules , a new facility would have 12 months to show that they are using all CON approved beds otherwise they would not be able to obtain additional beds. Because the law could not be applied retroactively this standard pertains only to new applicants. Department staff reported that the proposed Rules would be changed to indicate that this refers to CON authorized beds and not licensed beds.

Planning Regions

Department staff reported that the LTACH subcommittee engaged in significant discussions about which planning area map would be most appropriate to use for this service. Subcommittee members agreed that either the state service delivery region or the current rehab planning area map would be appropriate. Some LTACH committee members said that the recommendation to use the 12 state service delivery regions (SSDR) region map was predicated on maintaining consistency between

LTACH and other CON- regulated services, while others thought that it would be appropriate to maintain the same map as rehab services.

Department staff noted that some draft need models were completed using both the rehab planning areas and the state service delivery regions. More areas of need was evident using the SSDRs however overall occupancy rates were low and aggregate utilization within the planning areas was also quite low and would not result in the addition of new beds.

Department staff noted that in some models, where many planning areas were used, and where metropolitan Atlanta area was further divided, lots of numeric need became evident, particularly in adjacent counties. TAC members expressed concern about the proliferation of services and adverse impact on existing other providers.

Dennis Skelley noted that the state is over bedded with rehab beds and expressed concern about a similar outcome with LTACHs. He asked for clarification of the 2% utilization factor that was used in the need model. Department staff noted that a 2% utilization factor was used in the draft need methodology that was proposed by a member of the LTACH subcommittee. Gene Winters, made this proposed recommendation but the Department has been unable to get a rationale for this factor. Department staff solicited input from TAC members about other possible utilization factors, and asked for a justification for any components of the numerical need.

Dennis Skelley expressed concern about several changes that have occurred in the draft LTACH Rules. He said that the Rehab TAC had suggested that there is an 8% overlap with LTACH, based on studies from MEDPAC, yet the LTACH subcommittee has subsequently recommended 4% overlap.

Department staff noted that the need for rehab beds would likely be reduced to accommodate a certain percentage of patients that would go to an LTACH however the reverse would likely not be true. The Medicare definition doesn't seem to make allowances for LTACHs providing rehab care but it makes allowances for rehab facilities that provide care to LTACH patients.

Department staff noted that the proposed demand-based bed need calculation for long term care hospitals, using the SSDR map, and utilizing a 2% utilization factor, predicts a need for services in each region of the state with the exception of region four. Department staff said that if the rehab planning regions were used in the calculation of the numerical need methodology, population, beds needed, approved beds and days of care would remain the same, however the surpluses and deficits would become aggregated and utilization may change in the region. TAC members recommended that an additional column should be added to the LTACH bed need calculation model to capture the overlap of services.

Department staff asked members to decide whether they would like to use the four rehab planning regions or whether the SSDR map should suffice. TAC members said that critical mass is an area that needs to be considered. No consensus was reached on this issue.

Members asked for clarity about how Warm Springs and The Shepherd Center would be treated in the development of the numerical need.

Warm Springs- DHR/ORS has licensed Warm Springs as a Medicare classified long term care hospital. Warm Springs is no longer licensed as a rehab hospital. They are classified as LTACH.

Shepherd Center -Department staff said that The Shepherd Center can be excluded entirely from the inventory and some adjustment factor (utilization factor) could be factored in the need methodology; or alternatively they could be included entirely in the inventory. TAC members need to provide further guidance in this area.

Department staff said that they would conduct a special survey to determine how to allocate beds for the first year (rolling 12 months of data collection). Data collection would not change the first three years, but after year three it would change annually, based on the previous three years average.

Department staff asked committee members to determine what additional information and data were needed in order to determine the utilization factor. Department staff reminded TAC members that even if there is a numerical bed need, if the aggregate utilization of the planning area does not reach 75% no CON applications would be approved. Members discussed the suggested aggregate utilization and agreed that this should be changed from 75% to 85%.

Members agreed that the following standard should be retained. LTACH providers, who see greater than 25% of their patients with rehab diagnosis, are in violation of the LTACH Rules.

Members also requested information from other states about the following:

1. Utilization factors
2. Average length of stay (State of Georgia; 27.5)
3. Utilization factor (need methodology using four (4) planning areas)
4. county populations (to address minimum population standards)

Adverse Impact

Department staff read the current adverse impact statement as follows:

(a) An applicant for a new or expanded Long Term Care Hospital shall document that the establishment or expansion of its hospital will not have an adverse impact on existing and approved programs of the same type in its planning region. An applicant for a new or expanded Long Term Care Hospital shall have an adverse impact on existing and approved hospitals of the same type if it will:

1. *decrease annual utilization of an existing hospital, whose current utilization is at or above 85%, to a projected annual utilization of less than 75% within the first twelve months following the acceptance of the applicant's first patient; or*
2. *decrease annual utilization of an existing hospital, whose current utilization is below 85%, by ten percent over the twelve months following the acceptance of the applicant's first patient.*

TAC members suggested that 10% adverse impact standard is too high. They said that 10% is the current standard that is used for acute care hospitals which have a large number of annual admissions. LTACH facilities are smaller and have a smaller patient base. Members proposed an adverse impact standard of 3-5 %.

Department staff agreed to provide data on the number of admissions for every rehab and LTACH facility in the state in order to decide on an appropriate adverse impact standard.

Exception to Need Standard

Following the review of this standard, TAC members raised questions about the 50-mile radius. Department staff noted that the LTACH subcommittee increased the population base from 40,000 to 75,000 because they wanted to assure that there would be a critical population base. The current Rehab Rule has an exception standard that exempts the applicant from meeting the adverse impact standard, if the applicant proposes a program that will be located in a county with a population of less than 40,000 and located a minimum of 50 miles away from any existing program in the state. Members said that the Rehab Rules and LTACH Rules should have similar standards and they recommended that the rehab rules be changed to reflect " applicant proposing a program to be located in a county with a population of less than 75,000 and to be located a minimum of 50 miles away from any existing program in the state".

Department staff summarized the following requirements:

1. Most of standards in the LTACH Rules parallel those of Rehab Rules
2. Minimum number of beds; 40 freestanding facilities; 20 beds (hospitals-within-hospital
    a. If applicant is seeking to increase the number of beds, they must increase by at least 10 beds or 10% beds without submitting a CON providing the cost to do so does not exceed the CON expenditure threshold;
3. JCAHO accreditation within 24 months
4. DHR/ORS licensure standards
5. Financial accessibility
    a. If there are two competing applications in the same area, if one provider met the commitment while the other paid a fine to satisfy this commitment, the provider that met the commitment would receive favorable consideration in the review process, all else being equal. Department staff noted that the fine is paid to the State's Indigent and Charity Care Trust Fund.

Access to Care - 111-2-2-.36(i)(4)

Department staff indicated that the following standard was deleted from the proposed Rules

> *4. providing documentation of current or proposed charges and policies, if any, regarding the amount or percentage of charges that charity patients, self pay patients, and the uninsured will be expected to pay.*

The Department staff noted that few applications to provide services for traumatic brain injury patients are received annually. Matt Jarrard provided the current need methodology for TBI.

PUBLIC COMMENTS

The sign in sheet indicated that noone wanted to present before the committee.

NEXT STEPS & ADJOURNMENT

Department staff requested that members review the draft TBI data and to further examine the need methodologies for LTACH and rehab in anticipation of the next meeting. Members were reminded that all of these Rules should parallel each other so where they would recommend a change in one, it would automatically be changed in the others.

Department staff indicated that the next Health Strategies Council meeting is May 19th.

The next meeting was scheduled for Thursday, April 20th at 1:00-4:00 pm. There being no further business, the meeting adjourned at 3:05 pm.

Respectfully Submitted by

Brigitte Maddox and Stephanie Taylor